DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1	085009	A. BUILDING _____ B. WING _____	C 01/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

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F 000	INITIAL COMMENTS Revised report as of 2/16/2010. F 387 removed from the federal report and cited on the state report. An annual survey and complaint visit was conducted at the facility from January 4, 2010 through January 13, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included eighteen (18) admission and thirty (30) census residents in Stage I. The Stage II sample included twenty-four (24) residents.	F 000	**Disclaimer Statement** Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. This plan represents the facility's credible allegation of compliance as of 03/19/10.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 1. R65's patch was removed immediately upon discovery by the nurse and appropriate clinical interventions including vital signs were taken and found to be within normal limits, monitoring of R65's status and remained unchanged from baseline. Designated individuals were notified including the charge nurse, physician and POA (daughter) of the additional patch. 2. Any resident identified to have a medication error will automatically have a thorough investigation, by the ADOHS/or designee to determine the root cause, including review of the medication administration system. 3. Any investigations concerning allegations of neglect or medication errors will now require a concurrent review by the QI chairperson. The pharmacy	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Health Services — (X6) DATE: 3/1/10

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to thoroughly investigate an allegation of neglect for one (R65) out of 24 sampled residents. Cross refer F333. Review of R65's "Accident/Incident Report" dated 9/25/09 in which R65 was found to have two Duragesic patches on her body. The facility's investigation of the allegation of neglect lacked evidence that the medication administration system was reviewed to determine whether this may have contributed to the medication error. An interview with the Director of Health Services (E1) on 1/12/10 revealed that the facility's investigation did not include a review of the system. Findings reviewed with administration on 1/13/10.	F 225	Cont. F 225 provider will be notified by the DOHS of system errors, in order to implement corrective procedures. 4. Findings of internal investigations will be reported monthly (every 30 days) at the QI meeting for the next 3 months followed by quarterly meetings for one year.	03/19/10 and On-going
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	F253 1. Rooms #9, 18, 19, 29, 32, 33, 34, 36, 37 door jams will be painted and pre-formed laminate will be installed on areas affected. Rooms #30, 35, 38, and 41 door jams and heaters will also be painted and receive a pre-formed laminate installed to the affected areas. 2. Rooms where staff are utilizing mechanical lifts will have pre-	

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F 253	Continued From page 2 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made in the resident rooms throughout the survey, 01/04 to 01/13/2010, it was determined that the facility failed to provide maintenance services to keep rooms in good repair. Findings include: 1. The paint on the door jamb of the bathrooms in rooms # 9, 18, 19, 29, 32, 33, 34, 36, and 37 was chipped and unsightly. 2 The paint on the door jamb of the bathrooms and heater units in rooms # 30, 35, 38, and 41 was chipped and unsightly.	F 253	Cont F 253 formed laminate installed on door jams and other areas that may be affected by damage by the lifts. 3. Any staff responsible for the utilization of a mechanical lift will be instructed on practices to decrease damage to door jams. Remediation on how to generate a work order will be completed for health center staff utilizing mechanical lifts. 4. Audits will be performed by General Services every two weeks for 3 months and quarterly thereafter for one year.	03/19/10 and On-going
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE¿REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	F280 1. R18's care plan will be revised to include all areas of current assessed interests that include music, nail care, exercise and religious services (chapel). R36's non-pharmacological approaches including such as repositioning, back rubs and offer toileting. R16's care plan will be revised to include anxiety medication. Also identification of behaviors as manifested such as yelling out, rudeness, and refusals of care and non-pharmacological interventions such as 1:1, offering activity of choice as crocheting.	

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F 280	Continued From page 3 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R18, R36 and R16) out of 24 sampled residents the facility failed to ensure the care plan was revised to reflect assessed needs. Findings include: 1. R18 had an initial activity assessment dated 9/27/09 that included current interests of cards, dance/exercise, sports, music, reading, religious, outdoors, tv, garden/plants, talking, parties, outings, and paint (portraits). An activity note dated 10/21/09 documented "family still requests she provided with nails and attendance to exercise". An interview with a family member on 1/6/10 revealed that the family requested R18 attend music/dance, exercise and religious activities. Review of the resident's activity care plan dated 7/24/08 and last updated 1/24/09 addressed the residents interest in music and dancing but did not include interests in exercise and religious activities. Review of R18's activity attendance records for the past 4 months and interview with the activity director (E11) revealed exercise, religious and music activities. E11 confirmed the care plan was not updated to reflect the resident's interests. 2. Cross refer F329 example #1. R36 had an ongoing physician's order for Lunesta	F 280	Cont. F 280 2. All residents are assessed quarterly and with any significant change in condition by the MDS/Unit Manager Coordinator; any assessed changes will generate a revised plan of care. 3. Multidisciplinary team members will meet routinely to review and identify resident assessed needs and revise care plans as appropriate. 4. Based on schedules of care plan meetings distributed by MDS Coordinator, five (5) charts will be audited monthly by the Social Worker to confirm assessed changes have generated a revision in the plan of care; the outcome of the audits will be reported on at the QI meeting for 3 months and then quarterly times one (1).	03/19/10 and On-going

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F 280	Continued From page 4 (sleeping pill) 1 mg every night for insomnia. The resident's care plan did not reflect non-pharmological approaches to help with insomnia. 3. Review of the 1/2010 monthly physician orders revealed that R16 was ordered Xanax (for anxiety) 0.25 mg 1 tablet by mouth every 6 hours as needed on 8/10/09 for behavior/anxiety. Review of the 10/09 through 12/09 MARs (medication administration records) reflected that R16 received Xanax 2-3 times per month. Review of R16's record revealed that the facility developed a care plan for psychotropic drug use related to depression, last updated on 9/30/09. The facility, however, failed to revise the care plan to include anxiety medication, including measurable goals, identification of behaviors to be monitored, and non-pharmacological interventions to be considered prior to the administration of Xanax. During an interview with E4 (staff development) on 1/8/2010, she stated that a mood/behavior care plan should have been implemented for R16.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and policy review, it was determined that the facility failed to provide services that met	F 281	F281 1. R65 was ordered additional as needed pain (PRN) medication to the medication regimen and is being assessed for pain at least once every shift. If a PRN medication is used, she is reassessed for the effectiveness of the PRN. R65 has also undergone planned kyphoplasty in an attempt to relieve her pain (Kyphoplasty is a minimally invasive spinal surgery procedure used to treat pain caused most commonly by osteoporotic compression fractures). 2. The MAR will be utilized to identify residents receiving routine or PRN pain medications.	

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F 281	Continued From page 5 professional standards of quality. The facility failed to provide a pain management program that met professional standards of quality for one (R65) out of 24 sampled residents. Findings include: Cross refer F309. The facility failed to ensure that the pain management protocol for R65 met the professional standards of clinical practice as defined by the American Geriatrics Society. In particular, this facility failed to record a pain assessment in a way that facilitated regular reassessment and follow-up in a timely manner. In addition, as required by the standard of care, the facility failed to continue to use the same quantitative pain assessment tool used for the initial assessment of R65's pain on 10/8/09.	F 281	Cont. F 281 Additionally, all residents are prompted to have a pain assessment every shift via the electronic MAR; the electronic MAR will not allow the nurse to ignore the required response. 3. The systematic change to the current system is that the pain flow sheet will be reinstituted. Every shift each resident must be asked if he/she is experiencing pain or be observed for behavior that would indicate pain (while awake). If there is a yes response or behavior that indicates pain; the nurse will be required to initiate the pain flow sheet, implement interventions and reassess the effect of the interventions. (Attachment #1) All licensed nurses will be educated by 03/19/10 on the reimplementation of the pain flow sheet and standards of pain management; utilizing the Agency for Healthcare Research and Quality (AHQR) guidelines. 4. Twenty (20) residents each month for the next quarter will have their pain assessments audited by ADOHS/QI to ensure the standards of pain management have been met and the results of those audits will be reported to the QI committee.	03/19/10 and On-going
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, observation and review of facility's policy it was determined that the facility failed to provide care and services necessary to ensure adequate pain relief for one (R65) out of 24 residents. It was determined that the facility failed to reassess the pain and failed to	F 309	F309 1. R65 was ordered additional as needed pain (PRN) medication to the medication regimen and is	

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F 309	Continued From page 6 monitor the effectiveness of R65's pain management interventions related to the lower back pain secondary to the lumbar spine compression fracture. Findings include: R65 was readmitted from the hospital to the facility on 10/8/09 with diagnoses including status post fall, atrial fibrillation, chronic lower back pain, degenerative disc disease, dementia, osteoarthritis, and anxiety with depression. On 1/5/10 at approximately 11 AM, R65 was lying in bed and reported to the surveyor that her back always hurt and it "throbs." The initial Minimum Data Set (MDS) assessment dated 10/14/09 indicated that R65 was moderately impaired for daily decision making and experienced back pain on a daily basis with horrible or excruciating intensity. Review of the admission pain assessment dated 10/8/09 indicated R65 could verbalize pain on a scale of 1-10 and was experiencing lower back pain at a level 10 at the time of the assessment. R65 indicated that the pain is worst when sitting up and best when she is lying down. In addition, that medication has helped with managing the pain in the past and that the present pain medication regime was somewhat effective. R65's pain goal was "0" and that alternative interventions included repositioning and one and one. A care plan for pain management dated 9/17/09 included goals that R65 will reach/maintain a comfort and that R65 will have no episodes of untreated pain. Interventions included (1) Assess pain level when resident requests pain medication and evaluate effectiveness. (2) Administer medication for pain as ordered. (3) Provide	F 309	Cont F 309 being assessed for pain at least once every shift. If a PRN medication is used R65 is reassessed for the effectiveness of the PRN. R65 has also undergone planned kyphoplasty in an attempt to relieve her pain. (Kyphoplasty is a minimally invasive spinal surgery procedure used to treat pain caused most commonly by osteoporotic compression fractures). 2. The MAR will be utilized to identify residents receiving routine or PRN pain medications. Additionally, all residents are prompted to have a pain assessment every shift via the electronic MAR; the electronic MAR will not allow the nurse to ignore the required response. 3. The systematic change to the current system is that the pain flow sheet will be reinstituted. Every shift each resident must be asked if he/she is experiencing pain or be observed for behavior that would indicate pain (while awake). If there is a yes response or behavior that indicates pain; the nurse will be required to initiate the pain flow sheet, implement interventions, reassess the pain and monitor the effect of the interventions. (Attachment #1) All licensed nurses will be educated by 03/19/10 on the reinplementation of the pain flow sheet and standards of pain	

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F 309	Continued From page 7 opportunities for rest and relaxation (4) Assess pain level every shift (5) Consult (name of neurosurgeon) for low back pain. Although the R65 reported that non-pharmacological intervention of lying down made the pain better, the facility failed to incorporate this into the care plan. Review of the facility ' s policy titled " Pain Management" indicated a collaborative and interdisciplinary approach to pain control through appropriate pain assessment and pain management at a level acceptable to the resident. The management will include pharmacological and/or non-pharmacological strategies. Procedures included: #2 Each shift the resident must be asked if he/she is experiencing pain or observe resident for behaviors indicating pain (while awake). If pain is indicated, refer to Pain Flow Sheet (PFS). #3 A care plan will be initiated if pain is present. #4 Resident will be asked about pain within two hours of implementation of an intervention to determine the effectiveness of treatment. Document the effectiveness of treatment on the PFS. Interview with the Director of Health Services (E1) on 1/20/10 at 10 AM revealed that the facility is no longer utilizing the PFS since transitioning to the electronic pharmacy system on 7/1/09. Thus, any assessment of pain, intervention, and reassessment of the pain would be documented on the electronic Medication Administration Record (MAR) or in the nurses notes. Review of the attending physician's (E8) follow-up visit note dated 10/21/09 documented R65 with continued complaints of lower back pain with radiation to the right lower extremity and that the	F 309	Cont F 309 management; utilizing the AHQR guidelines. 4. Twenty (20) residents each month for the next quarter will have their pain assessments audited by ADOHS/QI to ensure the standards of pain management have been met and the results of those audits will be reported to the QI committee.	03/19/10 and On-going

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F 309	Continued From page 8 resident has been on Duragesic 25 mcg. (a narcotic pain medication administered continuously around the clock for treating moderate to severe pain) as well as use of oxycodone (a narcotic pain medication administered by mouth for treating moderate to moderately severe pain) on an as needed basis. The plan was to change the pain medication regime to routine doses of oxycodone 5 mg. four times per day as well as the use of Xanax (a medication to treat symptoms of anxiety) for anxiety as needed. Additionally, the visit note indicated "if the pain continues to be an issue, we can always increase the oxycodone but I will hold off on the Duragesic 25 mcg. for now." Review of initial neurosurgical consult for the lower back pain dated 11/16/09 documented R65 with multilevel disk disease throughout the spine with some evidence of spinal stenosis with evidence of a L2 (lumbar spine #2) compression fracture with some acute or subacute changes. Kyphoplasty (minimally invasive spinal surgery procedure used to treat painful, progressive vertebral compression fracture) was considered and planned for the compression fracture on 1/28/10. Review of the MAR for November 2009, December 2009, and January 2009 revealed that the resident was on Duragesic 25 mcg./hour transdermal patch every 72 hours, Lidoderm External Patch 5% (a medication to treat pain along the nerve), Oxycodone 5 mg. by mouth every 6 hours, and Tylenol 650 mg. (a medication to treat mild pain) by mouth three times per day. In addition, the above MARs documented that the resident was asked if she was experiencing pain	F 309		

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F 309	Continued From page 9 every shift and her response. Review of the November 2009 MAR documented that R65 reported pain for 49 (53%) out of 93 shifts. Neither the MAR or the nurses notes indicated that the nurses assessed the intensity of the pain utilizing the standardized quantitative pain assessment instrument that was used for the initial pain assessment on 10/8/09 for R65. For 24 (49%) out of the 49 reports of pain, interventions were documented, however, no reassessment of the effectiveness of the intervention was documented. Review of the December 2009 MAR documented that R65 reported pain for 21 (22%) out of 93 shifts, however, record review lacked evidence of pain assessment that included location and intensity of pain. In addition, for 4 (19%) out of the 21 reports of pain, interventions were documented, however, no reassessment of the effectiveness of the intervention was documented. Record review revealed that R65 had an epidural steriod injection on 12/17/09 in the lumbar spine region. Review of the January 1-12, 2010 MAR revealed that R65 reported pain for eight (23%) out of 34 shifts, however, record review lacked evidence of pain assessment. Although the facility initially assessed R65's lower back pain on 10/8/09 and implemented new pharmacological interventions on 10/24/09 for pain management, the facility failed to reassess and monitor the effectiveness of these	F 309		

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F 309	Continued From page 10 interventions as it related to resident's goals and current standards of practice. The current pain management standards by the American Geriatrics Society includes: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. An interview with R65's attending physician/facility's medical director (E8) on 1/13/10 at approximately 10 AM revealed that his assessment was that R65's pain was being managed with the above medication regime and that it was his assessment that the R65 did not require any as needed (PRN) pharmacological intervention. In addition, E8 relayed that his assessment was that some of the reports of pain is related to R65's behavior. However, E8 did confirm that the facility's expectation was when a resident complains of pain, the licensed staff nurse would assess the pain. During this interview, E8 relayed to the surveyor that the facility has identified the need to review and revise the current pain management policy and procedure. Findings reviewed with administration on 1/13/10.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	F329 1. R36's physician's orders were reviewed by the physician and the consultant pharmacist with particular attention focused on the hypnotic drug Lunesta. Identification of specific behaviors	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	C 01/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

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F 329	Continued From page 11 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R16 and R36) out of 24 sampled resident the facility failed to ensure medications were adequately monitored and not used for an excessive duration. Findings include: 1. R36 had a current physician's order dated January 2010 for lunesta (sleeping pill) 1 mg every evening for insomnia. A pharmacy consultant review dated 8/1/09 documented "Resident is currently receiving Lunesta 1 mg HS on a nightly basis. This is greater than the recommended CMS dosage for	F 329	Cont. F 329 such as insomnia and restlestness for the use of the medication and identification of non-pharmacological interventions such as back-rubs, re-positioning and offering of toileting will be care planned and monitored accordingly. R16 physician's orders were reviewed by the physician and the consultant pharmacist with particular attention focused on the anti-anxiety drug Xanax. Identification of specific behaviors include yelling out and aggressive towards staff for the use of the medication and identification of non-pharmacological interventions such as 1:1, offering activities of choice as crocheting and re-assignment of staff as appropriate will be care planned and monitored appropriately. 2. An audit will be performed by the pharmacy consultant on all resident's charts utilizing anti-anxiety or hypnotic agents monthly. Upon identification, medications will be reviewed with the primary care physician to ensure appropriate care plan revisions appropriate monitoring occur. 3. MDS Coordinator/Unit Manager will be re-educated by 03/19/10 on the importance of monitoring medications for excessive durations of all residents, if appropriate, will	

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F 329	Continued From page 12 this agent, in the elderly (1 mg HS PRN max 9 consecutive nights) Recommendation: Please consider changing order to 1 mg HS PRN, max 9 consecutive nights. If this total daily dosage is to continue, please document risk vs reward of decreasing dose". A pharmacy consultant review dated 11/20/09 documented "increased risk for falls with Lunesta and Pristiq. Please document non-drug interventions for insomnia and consider trial at prn Lunesta". The physician responded to the 8/1/09 consult on 1/4/10 by documenting "currently on lowest dose sleep pattern improve with treatment". There was no response on file for the 11/20/09 recommendation. Interview with the DON (E1) confirmed that there was no response found for the 11/20/09 review and there was a delay in the physician responding to the 8/1/09 review. It was confirmed with the unit manager (E5) that the care plan did not contain non-pharmological interventions. The only non-pharmological intervention on the care plan was to provide a quiet environment. There was no evidence that the resident's sleep patterns were being monitored. The facility administered Lunseta on a nightly basis without adequate monitoring for sleep response and in the absence of non-pharmological interventions. 2. The facility failed to monitor for adverse effects, and failed to list symptoms that led to the use of antianxiety medications and the non-pharmacological interventions that were attempted for R16.	F 329	Cont. F 329 be care planned accordingly with determined review dates. 4. All residents utilizing anti-anxiety or hypnotics agents will be reported to the QI Committee monthly for 3 months and once quarterly for effective monitoring of these drugs.	03/19/10 and On-going

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F 329	Continued From page 13 Review of the 1/2010 monthly physician orders revealed that R16 was ordered Xanax (for anxiety) 0.25 mg 1 tablet by mouth every 6 hours as needed on 8/10/09 for behavior/anxiety. Review of the 10/09 through 12/09 MARs (medication administration records) stated that R16 received Xanax 2-3 times per month. Record review revealed that the facility failed to have a care plan for the use of Xanax. Record review additionally revealed lack of identification and monitoring for adverse effects related to Xanax, behaviors that led to the use of the medication and what non-pharmacological interventions were attempted. The facility administered Xanax to R16 without adequate monitoring and in the absence of non-pharmacological interventions. Findings were confirmed with E4 (staff development nurse) and E12 (staff nurse) during interviews on 1/8/2010.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of hospital records and other facility documentation it was determined that the facility failed to ensure that one (R65) out of 24 residents were free of any significant medication errors. R65 was observed with two Duragesic 75 mcg.	F 333	F333 1. There is no corrective action that can be taken to correct this medication error event for R65 due to nursing error of improper medication pass protocol. The patch was immediately removed upon discovery by the assigned nurse. Vital signs were taken and were normal for R65's baseline and monitoring of R65 was performed. Narcan was administered at the discretion of the physician and R65	

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F 333	Continued From page 14 transdermal patch on her body resulting in the need for emergency administration of an antidote (Narcan). Findings include: R65 was originally admitted to the facility on 9/16/09 with diagnoses that included contusion of the right hip status post fall, degenerative disc disease, chronic low back pain, atrial fibrillation, hypertension, osteoarthritis, severe dementia, and anxiety. Review of the facility's "Accident/Incident Report" dated 9/25/09 completed by staff nurse (E10) documented that the resident had a two Duragesic 75 mcg. patches on her upper body at approximately 9 AM; one dated 9/22/09 located on the left anterior chest and the other dated 9/25/09 on the left upper back. The patch dated 9/22/09 was removed immediately and nurse practitioner (E9) contacted. E9 ordered for close monitoring and to notify him of any changes. Nurse's note dated 9/25/09 timed 9:50 PM noted that the assigned Certified Nursing Assistant (E16) reported that resident had been more unsteady this evening and vital signs were obtained by the charge nurse which noted within the normal range for this resident (temperature 98.4F, pulse 72, respiration 20 and blood pressure 140/60). Subsequent nurse's note dated 9/26/09 timed 3:30 AM documented "entered room to assess resident, B/P 120/58, pulse 45, oxygen saturation 67-71 at 12:45 AM. Oxygen at 2 liters per minute was started and oxygen saturation increased to 88%. On call physician was contacted and order was given to administer Narcan [a drug used to counter the effects of opioid /morphine overdose,	F 333	Cont. F 333 was sent to an acute care facility to the Emergency Department for evaluation and admitted for anemia, unrelated to the patch placement. The nurse (E13) placing the patch on 09/25/09 was terminated for not following proper medication pass protocol. 2. When any resident has an order entered by a nurse and that medication is not displayed, pharmacy services will be notified immediately for assistance prior to administering the medication. 3. All licensed staff will be re-educated by 03/19/10 on proper medication pass procedure, the proper use of the documentation omission record, use of the 24 hour pharmacy support center, computerized order entry procedures and the MPS nursing reference manual. Documentation omission records will be delivered to the ADHOS or designee for review and then placed on the resident's medical record. 4. All medication errors will be tracked by QI Coordinator and reported to the QI Committee for 3 months then quarterly for one year.	03/19/10

On-going

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F 333	Continued From page 15 specifically used to counteract life-threatening depression of the central nervous system] .4 mg. IM (intramuscularly) and if not improving in 15 minutes to send to emergency room for evaluation. At 12:50 AM, Narcan .4 mg. was administered and at 1 AM, 911 was called to transfer R65 to the emergency room. Nurse's note documented at approximately 1:30 AM, R65 was sent to the emergency room for further evaluation with vital signs pulse 54, respiration 15, blood pressure 150/52, and oxygen saturation of 91% on 3 liters of oxygen per nasal cannula. Review of hospital history and physical noted R65 upon arrival to emergency room was lethargic but not in respiratory distress. R65 was admitted for upper gastrointestinal bleed most likely secondary to use of aspirin. An interview with the attending physician on 1/8/10 at approximately 3 PM revealed that his assessment of the above incident was that R65 was not overdosed by the two Duragesic patches that were observed on 9/25/09 at 9 PM but rather it was related to the gastrointestinal bleeding. Review of written statement dated 9/28/09 by staff nurse (E13) who applied the Duragesic 75 mcg. patch dated 9/25/09 documented that "there was no indication that the resident had an old patch on her body and "there was no site indicated on the administration screen." An interview with E13 on 1/11/10 at approximately 12 noon revealed that when she selected the Duragesic 75 mcg. in the computerized pharmacy system for R65, the system failed to alert her of the prior date of administration or location, thus, E13 assessed that this was a new order.	F 333		

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F 333	Continued From page 16 Interviews with staff nurse (E14) who completed the "MPSRx" form titled "MPSRx Documentation Omission/Inaccuracy Entry dated 9/22/09 revealed that since she was not able to document the administration of Duragesic 75 mcg. on 9/22/09 at 10 AM in the system due to this order not appearing in the system, she completed the form and placed this form in the bin for the Director of Health Services (E1). E14's understanding was that if this form was completed within 48 hours, corrections can be completed in the system. Review of the September 2009 MAR printed from the electronic pharmacy system lacked evidence that Duragesic 75 mcg. patch was administered on 9/22/09. Review of the "Controlled Substance Proof-of-Use Record" for the Duragesic patch noted one patch was obtained on 9/22/09 and one on 9/25/09. An interview with E1 on 1/12/10 at approximately 11 AM revealed that the above form was retained in a binder located in the medication room and if any staff nurse had any questions related to medication administration, the staff nurse can refer to this binder for information. During this interview, the surveyor requested the facility's policy in updating the MAR for the above situation. On 1/14/10, the surveyor was faxed a policy titled "Correct Inaccurate Clinical Documentation Entries" as a follow-up to the 1/12/10 request. An interview with a representative of the pharmacy system (P1) on 1/20/10 at approximately 1 PM revealed that the above form	F 333		

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F 333	Continued From page 17 is not to be used to document medication omission event and that the above policy refers to correction of clinical documentation. Additionally, the representative relayed the correction in the MAR should have been completed by contacting the pharmacy. Lastly, the representative did confirm that since the 9/22/09 Duragesic 75 mcg. patch administration was not in the pharmacy system, E13 would not have received the date and location of the patch during medication administration on 9/25/09.	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS¿ COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (2) (E40 and E16) out of 24 sampled residents the facility failed to ensure dietary snacks were documented to include planned snack and consumption. Findings include: 1. The Registered Dietitian (RD) (E2) on 10/6/09 indicated in her notes for R40 that an evening	F 514	F514 1. R40 and R16's record will be updated to reflect dietary snacks and documentation of their consumption. 2. Any resident with dietary snacks has the potential to be affected. Complete chart audits of residents on a dietary snack will be performed and updated to reflect appropriate documentation of delivery of the snack and the amount consumed. 3. Care Plans, including the CNA's electronic plans, will be updated to reflect the dietary snack and the amount consumed. Licensed staff and aides will be educated on the importance of the delivery of the snacks and documentation of the amount consumed.	

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F 514	Continued From page 18 snack of peanut butter and jelly sandwich with milk was to be initiated to prevent further weight loss. The approach was included on the care plan. Review of facility records both paper and electronic lacked evidence that the snack was included on the aides "adl care plan" or the nursing administration records (treatment and/or medication) to document implementation and consumption. An interview on 1/12/10 with the RD (E2) revealed that the snack should have been documented somewhere in the resident's record. The snack was on the dietary list to be delivered to the unit every evening. 2. A RD's (E2) dietary note, dated 12/29/09, ordered a mid-afternoon snack, daily for R16 to prevent weight loss. Review of facility records both paper and electronic lacked evidence that the snack was included on the aides "adl care plan" or the nursing administration records (treatment and/or medication) to document implementation and consumption. The snack was on the dietary snack delivery list as being sent to the unit each day.	F 514	Cont. F 514 4. Dietary snacks will be place on the CNA's electronic plan of care as well as the MAR for nursing to ensure dietary snacks are delivered and that the documentation of the percentage of the dietary snack consumed is performed.	03/19/10 and On-going

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085009	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 1/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the residents room or roommate in the facility is changed This REQUIREMENT is not met as evidenced by: Surveyor: 14925 Based on record review and staff interview, it was determined that for one (R48) out of 24 sampled residents there was no notification of a new roommate assignment Findings include: 1. Record review of R73's chart revealed that this person was admitted to the facility on 12/26/09. R73 was being cohorted with R48. Staff interview with E6 and E1 on 1/12/10 indicated that notification of the residents about room or roommate changes was handled by the nursing staff on the unit. Review of the nurses, activities and social services notes for R48 had no indication that the resident was informed of receiving a roommate on 12/26/09 prior to the roommate's arrival on that date.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Methodist Manor House POST IDR

DATE SURVEY COMPLETED: January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. An annual survey and complaint visit was conducted at the facility from January 4, 2010 through January 13, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included eighteen (18) admission and thirty (30) census residents in Stage I. The Stage II sample included twenty-four (24) residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services to Residents**	3201.6.0 Services to Residents
3201.6.1	**General Services**	32016.1 General Services
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	3201.6.1.1 Cross refer to the CMS 2567-L survey report date 01/13/10, F281, F309, F329, F333

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DATE SURVEY COMPLETED: January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 1/13/2010, F281, F309, F329 and F333.	
3201.6.5	**Nursing Administration**	3201.6.5 Nursing Administration
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 1/13/2010, F280.	3201.6.5.7 Cross refer to the CMS 2567-L survey report date 01/13/10, F280
3201.6.9	**Housekeeping and Laundry Services**	3201.6.9 Housekeeping and Laundry Services
3201.6.9.1	**The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors,**	3201.6.9.1 Cross refer to the CMS 2567-L survey report date 01/13/10, F253

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	for the interior and exterior of the facility. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 1/13/2010, F253.	3201.10.0 Records and Reports
3201.10.0	**Records and Reports**	3201.10.1.2
3201.10.1.2	**History and physical examination prepared by a physician within 14 days of the resident's admission to the nursing facility. If the resident has been admitted to the facility from a hospital, the resident's summary and history prepared at the hospital and the resident's physical examination performed at the hospital, if performed within 14 days prior to admission to the facility, may be substituted. A record of subsequent annual medical evaluations performed by a physician must be contained in each resident's file.** **Based on record review and interview it was determined that one (R65) out of 24 sampled residents did not have the documented physician visits at the required frequency. Findings include:**	1. No corrective action can be accomplished for R65 due to the nature of this visit. 2. All newly admitted residents have the potential to be affected. Admission History and Physical forms, part of the admission packet, will be identified that a physician must see the resident initially. 3. Both the Medical Director and his designee will be provided with the regulations and interpretive guidelines governing physician services. The Unit Manger in collaboration with the physician provider will develop a visit schedule to ensure compliance. 4. Random audits will be performed by the Social Worker on all new admissions for the next 3 months, then quarterly for one year. Audit results will be reported to the QI committee. Completion date: 03/19/10 and On-going

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DATE SURVEY COMPLETED: January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	R65 was originally admitted to the facility on 9/16/09. Record review revealed an admission history and physical that was completed by a Nurse Practitioner (E9) on 9/18/09. The first visit note by the physician (E8) was dated 10/21/09. An interview with E9 on 1/8/10 revealed that the facility practice was that the NP and the attending physician rotated every three months and since E9 was assigned to the facility when R65 was admitted, E9 completed the admission history and physical. E9 relayed that he was not aware that he and the physician were required to rotate every other visit.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Methodist Manor House **POST IDR**

DATE SURVEY COMPLETED: January 13, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED